SYNOPSIS OF THESIS

DOCTOR OF PHILOSOPHY (Ph.D.) IN CLINICAL PSYCHOLOGY SUBMITTED TO RANCHI UNIVERSITY, RANCHI

"EFFICACY OF ECLECTIC PLAY THERAPY ON LIVED EXPERIENCES OF CHILDREN AND ADOLESCENTS WITH DISSOCIATIVE DISORDERS: A MIXED METHOD INTERVENTION STUDY"

by

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STATE OF ART

Dissociation is defined as "a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behaviour" (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition [DSM-5], 2013, p. 291). The ICD-11 further specifies that 'disruption or discontinuity may be complete, but is more commonly partial, and can vary from day to day or even from hour to hour' (WHO, 2020). Dissociative (Conversion) Disorders (D/CDs) are understood as a partial or complete loss of normal integration between memories of the past, awareness of identity and immediate sensations, and control of bodily movements (JORT, 1993). ICD-10, includes dissociative amnesia, dissociative fugue, dissociative stupor, trance and possession disorders, dissociative motor disorders, dissociative convulsions, dissociation anaesthesia and sensory loss, mixed dissociative (conversion) disorders, other dissociative disorders, and dissociative disorder unspecified under this category. These are common psychiatric disorders among children and adolescents, with the prevalence rate ranging from 12% to 31% in psychiatric settings (Srinath et al., 2005) in India. The most observed symptoms in the Indian context are pseudo-seizures or dissociative convulsion, abnormal movements, and fainting attacks (Murthy et al., 1994; Srinath et al., 1993). However, symptoms of amnesia and aphonia are less commonly seen. While the literature on dissociative (conversion) disorders gives no universally accepted unifying etiological model, several psychosocial interacting factors accounted for an increase in children's risk and vulnerabilities. Dissociation allows a child who cannot physically escape from extreme stress and terrifying experience to mentally exit the situation (Waters, 2016). The stressors from Indian context included disruptive family problems, sibling rivalry, peer problems, academic difficulties, and death in the family (Sethi et al., 2010; Sharma et al., 2005; Srinath et al., 1993). Identifying the presence of psychosocial stressors and appropriate interventions enhanced the treatment outcomes (Malhi & Singhi, 2002; Srinath et al., 1993). Psychosocial interventions were core treatments for dissociative disorders among children and adolescents (Prabhuswamy et al., 2006). However, often children and their families disbelieved the diagnosis and resisted psychological treatment approaches, due to the fear of being misunderstood as pretending to be sick (Hall-Patch et al., 2010; Malhi & Singhi, 2002; Stone et al., 2004). These fears associated with psychological explanation and adverse past treatment experiences not only hindered seeking appropriate help but also led to poor treatment outcome (Diseth & Christie, 2005). Adolescent perceptions, experiences,

and perspectives on their dissociate disorders, are essential while planning and implementing treatments, exploration of this area seems to have been inadequate. (Moyon et al., 2021).

Play therapy is a "structured, theoretically based approach to therapy that builds on the normal communicative and learning processes of children" (Schaefer & Drewes, 2014). It can be defined as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play (e.g., relationship enhancement, role-playing, communication, mastery, etc.) to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (Association for Play Therapy, 2018). Play has the distinctive ability to honour the child's emotional world and personal logic whilst concurrently offering the conditions to author an improved, more adaptive narrative (Stewart et al., 2016). Play therapy is an effective and growing approach to intervention for childhood disorders and trauma (Drisko et al.,2019; Goodyear-Brown, 2019).

Humans show a high extent of flexibility facing events that do not fit a proponent model of behaviour. This flexibility is associated with several psychological operations united under a general concept of cognitive control (Folstein and Van Petten, 2008). The cognitive control includes at least two operations: 1) operation of inhibition of an ongoing response pattern in order to avoid interference from irrelevant actions (Barkley, 1997; Aron, 2007) and 2) conflict monitoring operation detecting conflict when response tendencies are interfering with each other (van Veen and Carter, 2002; Botvinick, 2007).

In experimental conditions for studying cognitive control a GO/ NOGO paradigm has been used. In the conventional GO/NOGO paradigm two stimuli (for example of green and red color) are sequentially and randomly presented with relatively long (more than 1 s) inter-stimulus intervals (Gemba and Sasaki, 1989). The subject is preparing to make an action as fast and as precise as possible in response to the GO cues (for example green color) and has to withhold from the action in response to the NOGO cues (red color). Event related potentials (ERPs) recorded in the GO/NOGO paradigm exhibit two waveforms obtained in the difference NOGO– GO potentials and labeled correspondingly N2 NOGO (referred in this paper as N2 wave) and P3 NOGO (referred in this paper as P3 wave). The N2 wave is distributed over frontal–central electrodes and peaks between 250 and 350 ms (Pfefferbaum et al., 1985; Kok, 1986; Jodo and Kayama, 1992). The P3 wave follows the N2 wave and has a similar scalp distribution (Pfefferbaum et al., 1985; Kok, 1986; Jodo and Kayama, 1992). In the early research the N2 and P3 waves were considered

as a single complex N2/P3 (Simson et al., 1977). However recent research considers these waves as separate categories (Huster et al., 2010).

Self-esteem is the term used to describe a person's overall sense of self-worth or self-value. It is how you see yourself, how much you appreciate and like yourself, and your opinion of yourself. It also includes your sense of identity, your self-confidence, feeling of being competent and sense of belonging. Self-esteem is not just about liking yourself; it also means believing in yourself, valuing you own thoughts, feelings, opinions, needs, interests, and goals, and believing that you deserve care and consideration, respect, and love.

MOTIVATION

Researches shows that children and adolescents face lot of experiences, due to which they show emotional-based style of functioning, they are unable to cope with anxiety and regulate emotions along with self-esteem issues (Sinden, 1999). Though there are various treatment modalities available such as behavioural therapy, cognitive behavioural therapy, dialectical behaviour therapy, eye movement desensitization and reprocessing, as well as adjunctive therapies such as mindfulness and many more to deal with the issues of dissociative disorders. Play therapy has also been successfully adapted and tested for psychiatric conditions in which problems related to children and adolescents. (Jones & Landreth, 2002).Play therapy along with the art therapy techniques targets these areas to improve clinical symptoms as well as build adequate skills through the medium of play and art so that the individual can express themselves symbolically. Play therapy has been shown to be an effective medium to reach out for lived experiences and working on the coping difficulties, and self-esteem issues (Porter et al., 2009). Literature emphasizes the importance of a staged approach, beginning with the creation of a safe therapeutic frame prior to addressing stressful events. It is also a staged treatment, in which stressful events followed by behavioural and safety issues are addressed (Ford et al., 2005). Play therapy has been adapted for other mental_health problems that threaten a person's safety, relationships, work, and emotional well-being. Play therapy skills along with other behavioural techniques can help people to manage their dissociation symptoms (Kestly, 2014). Play Therapy in children can be useful at the stage of development, they tend to use play as a primary means of communication and expression. However, play therapy can also be effective for teenagers and even some adults, as many people can benefit from using creative expression as a means of processing emotions and resolving psychological difficulties. (Gupta et.al.,2023). Previous researches shows that the Play

Therapy module has been used in other disorders. However, entire module has not been used for children and adolescents with dissociative disorders.

Since there is dearth of literature focusing on management of dissociative symptoms in adolescents. The current study focuses on the biological, psychological and social aspect of the individuals. Besides self-esteem issues, the target can be enhancement of coping skills and anger management along with assessing and working on the cognitive aspect.

To assess the biological correlates, change in outcome variables after eclectic Play therapy, we propose to go for a task based EEG which would be first of its kind to be used in this population. The goal of the study is to introduce a holistic model among the population that would with a biological, psychodynamic and cognitive approach to work towards various impacted areas in children and adolescents with Dissociative disorder.

LITERATURE REVIEW

There is interplay of stressful psychosocial situation(s) with emotional states in symptoms manifestation among adolescents diagnosed with dissociative/conversion disorders. Adolescents with these disorders experience a feeling of being dejected, doubted, accused of being dramatic and feeling of misunderstood by significant others including doctor, traditional healer, teacher, relatives, and families. Loss of academic and daily activities, self-stigma associated with the illness, difficulties, and challenges in normalization were the negative experiences of these participants while living with the illness. Adolescent perceptions, experiences, and perspectives on their dissociative disorders, are essential while planning and implementing treatments. A qualitative study was done by Dickinson et.al., 2010 on Patients diagnosed with non-epileptic seizures: Their perspectives and experiences to examine patients with non-epileptic seizures made sense of their illness experiences and obstacles faced by them while seeking treatment. Exploration to their illness perspectives and different modes of reasoning in regard to their illness and treatment experiences was done and on thematic content analysis Emergent themes included accounts of adverse and positively perceived life events coinciding with illness onset, head injury, presence of caregivers during events, comorbid illness, and previously witnessing epilepsy in others.

Moyon et al., (2021) studied Subjective experiences of dissociative and conversion disorders among adolescents in India. This study was done to examine their understanding about the illness and the reason they put down to the cause of their illness. Thematic analysis identified the themes such as (1) Adolescents' attributing factors of the illness, (2) Cognitive and emotional appraisal of

stressful situation/s, (3) Adolescents' appraisal of different explanatory model, (4) Living with the Impact of the illness.

A study on Dissociating action inhibition, conflict monitoring and sensory mismatch into independent components of event related potentials in GO/NOGO task. In which the anterior N2 and P3 waves were decomposed into components by means of independent component analysis (ICA). Three of the independent components were selectively affected by the task manipulations indicating association of these components with sensory mismatch, action inhibition and conflict monitoring operations. According to sLORETA the sensory mismatch component was generated in the left and right temporal areas, the action suppression component was generated in the supplementary motor cortex, and the conflict monitoring component was generated in the anterior cingulate cortex.(Kropotov et al., 2011)

Gargiulo et al., 2022 conducted a study on Perceived stress, resilience, and stress coping in patients with drug resistant epilepsy and functional dissociative seizures and found that higher levels of perceived stress, anxiety, and depression, with lower levels of resilience and more difficulties in stress coping among Functional dissociative seizures (FDS) and Drug-resistant epilepsy DRE patients than controls. Patients with FDS have higher levels of depression and anxiety than patients with DRE. And further directed as Combined intervention strategies which enhance stress coping may be appropriate to direct treatment and psychotherapy.

In 2022 Krause-Utz conducted a study on Dissociation, trauma, and borderline personality disorder it was found that dissociation and its link to trauma and BPD is increasing. Dissociation is closely linked to other symptoms, such as emotion dysregulation, disrupted identity, and interpersonal disturbances. This may interfere with affective-cognitive functioning (e.g., interference inhibition), body perception, and treatment. Neurobiological findings are still diverse but hint towards increased activity in frontal regions (e.g., inferior frontal gyrus) and temporal areas during dissociative states. Differences in the definition and assessment of dissociation as well as sample characteristics (e.g., comorbidities, trauma history) hinder a straightforward interpretation and comparison of results.

Self-concept integration and differentiation in subclinical individuals with dissociation proneness was studied by Chiu et al., in 2017. The aim was to investigate how self-concept organization may differ among individuals with different levels of dissociation proneness. the findings suggests that individuals high in dissociation proneness have lower self-concept clarity and compartmentalize

self-aspects with more polarized evaluations. Notably, the association between dissociation proneness and evaluative self-compartmentalization held after controlling for childhood trauma, anxiety, and depression.

Wilson & Ryan (2006) did a study on Play therapy with emotionally damaged adolescents. The aim was to see that non-directive play therapy, given age-appropriate adaptations, offered an approach which, since it encompasses both play and verbal communication, well suited for addressing adolescent concerns, particularly those of early adolescence which showed how a more traditional non-directive counselling approach was combined with play therapy by the adolescents themselves, allowing exploration of emotional difficulties on all levels of mental functioning. The cases showed how traumatic or painful early memories may be reworked on a bodily and emotional level, without the feeling of over-intrusion risked by a directive or interpretive stance.

A study on Art Based Communication for Individuals with Dissociative Spectrum Disorders with quantitative and qualitative methods was designed to explore non-invasive ways art help people on the dissociative spectrum communicate their physical and psychological experiences to health professionals (HP). results showed significant pre-test to post-test increases in self-awareness for each of the groups after completing the art intervention. No significant differences were found between groups regarding pre-test, post-test and the change in self-awareness score. Participants in the dissociative group increased the number of positive words when expressing a connection to areas of the body after the art intervention as compared to before the art. Implications were mentioned as: the correct art medium, the art can create perspective shifts, give another way to express, and increase self-awareness. The study also found that the methodology was highly tolerable for outpatient individuals on the dissociative spectrum. (Cynthia, 2019).

PROBLEM TO BE INVESTIGATED

To explore the efficacy of Eclectic Play Therapy (EPT) on lived experiences and its consequences in children and adolescents with Dissociative disorders.

OBJECTIVES

1. To compare the severity of dissociative symptoms at baseline, 6^{th} week and 10^{th} week, between children and adolescents with dissociative disorder receiving eclectic play therapy as compared to treatment as usual.

2. To compare the change in health outcomes of lived experiences at baseline, 6th week and 10th week, between the children and adolescents with dissociative disorder receiving eclectic play therapy as compared to those receiving treatment as usual.
3. To compare the improvement in the symptoms of anxiety and depression at baseline, 6th week and 10th week, between children and adolescents with dissociative disorder receiving eclectic play therapy as compared to treatment as usual.
4. To compare the improvement of emotion regulation, coping and self-esteem at baseline, 6th week and 10th week, between children and adolescents with dissociative disorder receiving eclectic play therapy as compared to treatment as usual.
5. To compare the difference in electrophysiological measures at baseline, 6th week and 10th week, between children and adolescents with dissociative disorder receiving eclectic play therapy as compared to treatment as usual.
6. To assess the association of improvement in outcome variables with eclectic Play Therapy with various Socio-demographic clinical variables in children and adolescents with dissociative.

HYPOTHESES

1. There would be no significant difference in the severity of dissociative symptoms at baseline, 6th week and 10th week, between children and adolescents with dissociative disorder receiving eclectic play therapy as compared to treatment as usual.
2. There would be no significant difference in the health outcomes of lived experiences at baseline, 6th week and 10th week, between the children and adolescents with dissociative disorder receiving eclectic play therapy as compared to those receiving treatment as usual.
3. There would be no significant difference in the symptoms of anxiety and depression at baseline, 6th week and 10th week, between children and adolescents with dissociative disorder receiving eclectic play therapy as compared to treatment as usual.
4. There would be no significant difference in improvement of emotion regulation, coping and self-esteem at baseline, 6th week and 10th week, between children and adolescents with dissociative disorder receiving eclectic play therapy as compared to treatment as usual
5. There would be no significant difference in the electrophysiological measures at baseline, 6th week and 10th week, between children and adolescents with dissociative disorder receiving eclectic play therapy as compared to treatment as usual.

6. There would be no significant association in the efficacy of eclectic Play therapy in Socio-demographic and clinical variables in children and adolescents with dissociative disorder.

Primary Outcome Variable

- Improvement in dissociative symptoms in children and adolescents with Dissociative disorders.
- Health outcomes of lived experience in children and adolescents with Dissociative disorders.

Secondary Outcome Variables

- Anxiety
- Depression
- Coping
- Emotion regulation
- Self-esteem
- Electrophysiological measures as measured by event related potentials.

METHOD & MATERIALS

TENTATIVE CHAPTERS OF THE THESIS

- **Introduction**
- **Review of literature**
- **Aims**
- **Objectives**
- **Motivation**
- **Hypotheses**
- **Method and Materials**
  - **Venue and Study design**
  - **Sample**
  - **Sampling Method**
  - **Inclusion and Exclusion Criteria**
  - **Tools**
  - **Procedure**
  - **Statistical analysis**

- **Results**
- **Discussion**
- **Summary and conclusion**
- **Limitations and future directions**
- **Bibliography**
- **Appendices**

This synopsis is tentative, which may be modified depending upon the availability of cases, tools and other situations/exigencies.

Place of the Study: Erna Hoch Centre for Child and adolescent Psychiatry and K S Mani Centre for Cognitive neuroscience, Central Institute of Psychiatry, Ranchi.

Study Design: Prospective, hospital based, Experimental study

Sample: The sample size for the current study will comprise of 50 adolescents (both male and female) divided into 2 groups (study group and treatment as usual group).

Sampling Method: Purposive sampling; patients would be sequentially and randomly assigned to groups using random- table number sequence. The commencement of the first treatment session by the clinician will be done after the baseline assessment.

INCLUSION AND EXCLUSION CRITERIA

Inclusion criteria

- Meeting the criteria for F44 Dissociative (Conversion) disorder according to ICD-10, DCR (WHO, 2012)
- Age 10 to less than 18 years
- Both male and female
- Grade III Intellectual Capacity Average (50^{th} Percentile) and above
- Participants giving assent and primary caregiver giving informed consent.
- Individual Therapy

Exclusion criteria

- History of Organic Disorder
- History of substance abuse or dependence
- History of chronic or other significant general medical or neurological conditions
- Having physical/sensory disability

TOOLS

The psychological tools along with some structured interview schedules and electrophysiological measures will be administered with the children and adolescents with dissociative disorder for screening and baseline assessments followed by intervention and post assessment. To see the pre & post effect of the intervention.

1. **Informed Consent form and Participant Information Sheet**: Permission would be taken from the participants' parents/caregiver before conducting the study. The informed consent will provide information about the research purpose, procedure, duration, participant selection, voluntary participation and confidentiality of the study along with Certificate of Consent.
2. **Assent Form**: Permission would be taken from the participants before conducting the study. The Assent from will provide information about the research purpose, procedure, duration, participant selection, voluntary participation and confidentiality of the study along with Certificate of Consent.
3. **Socio- Demographic Data Sheet**: A semi-structured pro-forma, specially designed for the study was used to elicit the following socio-demographic information- name, age, sex, religion, educational level of the subject. Histories of present medical and psychiatric illness were elicited. Information related to the duration, causes and other area involved in dissociation.
4. **Clinical Information Sheet**: It includes description of the clinical variables like presenting complaints, history of presenting illness, family history of any illness or substance, past history of medical illness, past medical history, early childhood, developmental and scholastic history, and pre-morbid temperament. Information related to the duration of illness, causes, other area involved in dissociation.
5. **Standard Progressive Matrices (SPM)** (Raven, 1938): The SPM is a group or individually administered test that nonverbally assesses intelligence in children and adults through abstract reasoning tasks. Appropriate for ages 8-65, the SPM consists of 60 problems (five sets of 12), all of which involve completing a pattern or figure with a part missing by choosing the correct missing piece from among six alternatives. Patterns are arranged in order of increasing difficulty. Split-half method estimates result in values ranging from .60 to .98, with a median of .90. Raven provided test-retest coefficients for

several age groups: .88 (13 years plus), .93 (under 30 years), .88 (30-39 years), .87 (40-49 years), .83 (50 years and over).

6. **Multidimensional Inventory of Dissociation (MID)** (Dell, 2006): The Multidimensional Inventory of Dissociation is a multi-scale diagnostic instrument that is designed to comprehensively to assess the entire domain of dissociative phenomena. The MID has a breadth of coverage that is greater than the brief self-report instruments and structured interviews for dissociation. The MID is a 218-item instrument with 168 dissociation items and 50 validity items. It is written at a seventh-grade reading level. The MID uses an 11-point Likert scale format that is anchored by Never and Always The 2nd edition of The MID assesses 23 Symptoms of Dissociation. It includes six validity scales. Cronbach alpha value is 0.99.
7. **The McGill Illness Narrative Interview (MINI): An Interview Schedule to Elicit Meanings and Modes of Reasoning Related to Illness Experience (Groleau et al., 2007):** MINI is sequentially structured with three main sections that obtain: (1) A basic temporal narrative of symptom and illness experience, organized in terms of the contiguity of events; (2) salient prototypes related to current health problems, based on previous experience of the interviewee, family members or friends, and mass media or other popular representations; and (3) any explanatory models, including labels, causal attributions, expectations for treatment, course and outcome. Supplementary sections of the MINI explore help seeking and pathways to care, treatment experience, adherence and impact of the illness on identity, self-perception and relationships with others. Narratives produced by the MINI can be used with a wide variety of interpretive strategies drawn from medical anthropology, sociology and discursive psychology. MINI consists of 5 domains 1. Initial Illness Narrative, 2. Prototype Narrative, 3. Explanatory Model Narrative, 4. Services and Response to the Treatment and 5. Impact on life. As per by Dickinson et.al., 2010 the emergent themes included accounts of adverse and positively perceived life events coinciding with illness onset, head injury, presence of caregivers during events, comorbid illness, and previously witnessing epilepsy in others.
8. **Affective Reactivity Index (ARI)** (Stringaris et al., 2012): The DSM-5 Level 2—Irritability—Child Age 11–17 is an adapted version of the Affective Reactivity Index (ARI) that assesses the pure domain of irritability. The original version of the ARI, which

was validated in children ages 6–17, uses the same items as above but includes a past 6-month time frame.1 Each item on the scale is rated on a 3-point scale (0=not true; 1=somewhat true; 2= certainly true).

9. **Emotion Regulation Questionnaire for Children and Adolescents (ERQ–CA)** (Gullone & Taffe, 2012): The ERQ (Gross & John, 2003) comprises 10 items assessing the Emotion Regulation strategies of cognitive reappraisal (6 items) and expressive Supression (4 items). Items are rated on a 7-point Likert-type response scale. Higher scores on each scale indicate greater use of the corresponding ER strategy. The ERQ has been reported to have high internal consistency (alpha is.79 for Reappraisal, .73 for Suppression) and 3-month test–retest reliability (r=0.69 for both scales), as well as sound convergent and discriminant validity with both younger and older adults (Gross & John, 2003; John & Gross, 2004). Revisions included simplification of the item wording (e.g., "I control my emotions by not expressing them" was reworded to "I control my feelings by not showing them") and reduction of the response scale length to five points (1 strongly disagree, 2 disagree, 3 half and half, 4 agree, 5 strongly agree). The range of scores for each scale was 6 to 30 for the CR and 4 to 20 for the ES.
10. **Hamilton Anxiety Rating Scale (HAM-A)** (Hamilton, 1959): The HAM-A was one of the first rating scales developed to measure the severity of anxiety symptoms, and is still widely used today in both clinical and research settings. The scale consists of 14 items, each defined by a series of symptoms, and measures both psychic anxiety (mental agitation and psychological distress) and somatic anxiety (physical complaints related to anxiety). The HAM-A does not provide any standardized probe questions. Despite this, the reported levels of inter-rater reliability for the scale appear to be acceptable. Each item is scored on a scale of 0 (not present) to 4 (severe), with a total score range of 0–56, where <17 indicates mild severity, 18–24 mild to moderate severity and 25–30 moderate to severe.
11. **Childhood Depression Inventory (CDI-II)** (Kovacs, 1983): The Children's Depression Inventory 2nd Edition™ or CDI 2® is a comprehensive multi-rater assessment of depressive symptoms in children and adolescents from ages 7 to 17. It consists of 27 items *self-report inventory.* Responses are scored on a 0-2 scale, with 2 representing the severe form of a depressive symptom and 0 representing the absence of that symptom. The distribution statistics for the combined samples yielded an overall CDI mean of 9. 09, a standard

deviation of 7.04 and a cut-off score of 19 for the upper 10% of the distribution. Reliability assessed through coefficient alpha, item-total score product-moment correlations, and test-retest coefficients proved acceptable.

12. **The Social cognition and Object relation Scale- Global Rating Method (SCORS-G)** (Stein and Mulford, 2018): This scale consists of eight dimensions – Complexity of representation of People (COM), Affective quality of representation (AFF), Emotional Investment in Relationship (EIR), Emotional Investment in Values and Moral Standard (EIM), Understanding of Social Causality (SC), Experience and management of Aggressive Impulse (AGG) Self-Esteem(SE), and Identity and Coherence of Self (ICS) that are scored on 7-point anchored scale. These dimensions include the Inter-rater reliability for each of the dimensions based on alpha coefficients ranging from 0.81-0.92.
13. **Thematic Apperception Test (TAT), (Murry & Morgan, 1943):** Thematic Apperception Test (TAT) is a projective test consisting of a series of pictures. It was developed by Murry and Morgan in 1943. It consists of 30 achromatic picture cards and one blank card, it is shown to the both the sexes of different age groups involved in various activities some of the cards are gender specific. No clear agreed on scoring and interpretation system. The test requires the subject to tell a story for each card. Several TAT-type tests have been designed to study specific problem areas. Murray's Theory of Personality: • How individuals react with their environment. • How they are affected by their external forces. • How their attitudes, needs and values influence their reaction to world. • Murray developed a list of 28 needs and 24 possible forces in person's environment named as press. • He gave the concept of theme "a pattern of related needs and press" derived from early infantile experiences. In this study card number 1, 2, 3BM, 16 will be used to understand the themes for the adolescent.
14. **Adolescent-Coping Orientation for Problem Experiences (A-COPE)** (**Patterson & McCubbin, 1987**): The Adolescent-Coping Orientation for Problem Experiences (A-COPE), developed by Joan Patterson and Hamilton McCubbin (1983), is a coping inventory which has been designed to identify the behaviors adolescents find helpful in managing problems or difficult situations. It comprises 12 subscales. The reliabilities (Cronbach's alpha) of the subscales are Ventilating feelings (0.75) Seeking diversions (0.75) Developing self-reliance and optimism (0.69) Developing social support (0.75)

Solving family problems (0.71) Avoiding problems (0.71) Seeking spiritual support (0.72) Investing in close friends (0.76) Seeking professional support (0.50) Engaging in demanding activity (0.67) Being humorous (0.72) Relaxing (0.60).

15. **ERP (EBNeuro S.p.A- EPrime 3):** Event related Potential (ERP) recording will be done using Evoked Potential measuring system (EBNeuro), using Galileo NT software. The Galileo NT software contains specialized modules for acquisition, storage and display of biological signals, specially designed for management of encephalic signals; like Electrophysiology (EEG, video EEG), Polysomnography (PSG), Evoked Potential (EP), Event Related Potential (ERP) and Electromyography (EMG). The ERP is managed by Galileo NT database known as ERP GLANT. The N2 and P3 ERPs to the Go versus NoGo trials were used using 128 channels.

INTERVENTION

- Pre and Post Follow up measurement: (measurement at baseline, post intervention and at 1 month follow up)
- Module: Short-term Trauma Resolution by Combining Art in Play Therapy (Pifalo, 2009 & Hamil, 2011) and Solution Focused Sand tray Therapy for Children (Taylor, 2009). Basic Life Skills Course Facilitator's Manual (UNICEF, 2019).
- 12 Sessions, 1 hour for each session.
- 2-3 sessions per week

Module session wise description

Phases	**No. of sessions**	**Treatment objective**	**Therapeutic goal**	**Techniques to be used**
I	1	Orientation and rapport establishment. Baseline assessments	Rapport establishment. Introducing the intervention Discussing the goals Baseline assessments	Assessment tools
	1	Introduction of the therapeutic module and the process.	Establishing cohesion, disclosure and rapport establishment and creating safe therapeutic environment	House, tree, person test Friends with Clay Mandala art.
Il	1 –2	Narrating the lived experiences	Narrating own experiences without any rules and format, Description of thoughts and emotions simultaneously	Narrative writing/narrating the experiences and discussion

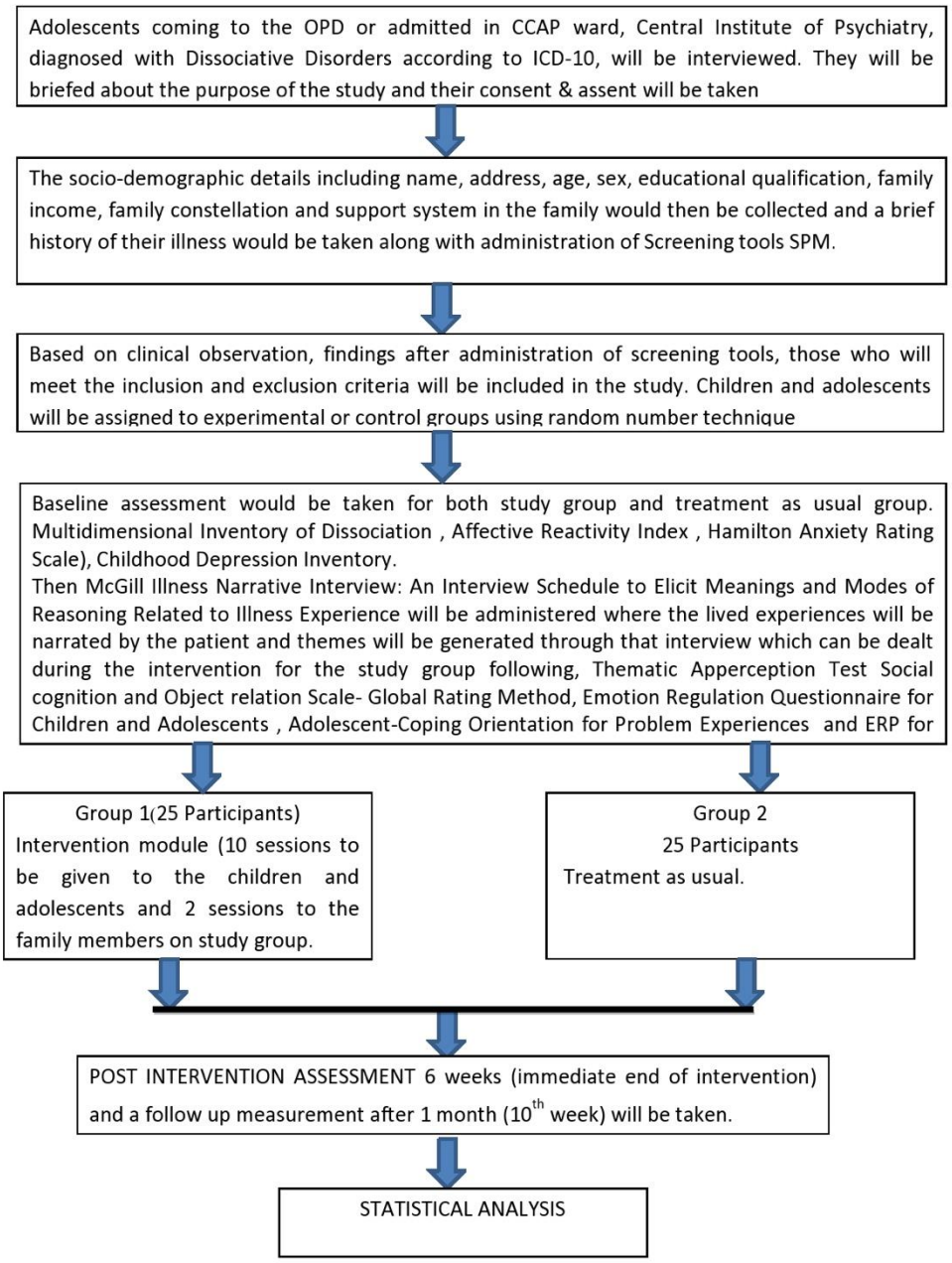
				Mapping those experiences (with stimulus such as sand tray)
	1	Processing the experiences	Share the lived experience	Lived narrative Hidden treasure (sand tray)
III	1	Working on Self	Work on self esteem	What is Self-Esteem Self confidence Personal inventory Treating oneself with respect Taking care of our basic needs
	1	Affective identification	Establish emotional literacy	Identifying basic emotions Play feeling detectives Emotional thermometer Making a shield
	1	Affective processing	Develop skills in self-expression	Creating feeling boxes/jars Reading other's emotions Grounding Anchor
	1	Developing coping skills	Practice focused breathing and relaxation	Belly breathing Mindfulness exercise (eating, breathing) Forgiveness exercise
	1	Parents involvement via using filial techniques	Defusing, debriefing and normalizing the emotions with the adolescent and validation of emotions with the guardians and giving the confidence that the parents are with them in any given situation	Role plays Board games Using art material and make an art piece with the same
	1	Identifying sources of support	Name personal resources	Creating strings of strength and role play

	1	Risk reduction and termination including caregivers	Establish personal boundaries	Draw a safe space and Post intervention assessment

PROCEDURE

The samples would be taken from Erna Hoch Centre for Child and adolescent psychiatry (CCAP) inpatient ward or in the Outpatient Unit at Central Institute of Psychiatry (CIP). The participants meeting the criteria for dissociative disorder as per ICD-10 will be briefed about the purpose of the study and their consent & assent will be taken. Based on clinical observation and scoring from the screening tools (SPM), those fulfilling inclusion and exclusion criteria will be enrolled for the study. Socio-demographic and clinical data sheet will be completed.

The participants would be taken by purposive sampling and would be randomly allocated to two groups. For group 1, 25 participants will be allocated those who will receive the therapeutic module of brief integrated intervention model. For group 2, 25 participants will be given treatment as usual. For group 1 and group 2, assessment measures at baseline will be done for. Baseline assessment would be taken for both study group and treatment as usual group. Multidimensional Inventory of Dissociation , Affective Reactivity Index , Hamilton Anxiety Rating Scale), Childhood Depression Inventory, Then McGill Illness Narrative Interview: An Interview Schedule to Elicit Meanings and Modes of Reasoning Related to Illness Experience which includes the domains such as Initial Illness Narrative, Prototype narrative, Explanatory Model Narrative, Services and Response to treatment and Impact on life will be administered where lived experiences will be narrated by the patient and themes will be generated through that interview which can be dealt during the intervention for the study group following, Thematic Apperception Test Social cognition and Object relation Scale- Global Rating Method, Emotion Regulation Questionnaire for Children and Adolescents, Adolescent-Coping Orientation for Problem Experiences and ERP for both the groups. The proposed intervention module would be offered to the study group. Assessment measures will be applied after 6 weeks (immediate end of intervention) and a follow up measurement after 1 month (10^{th} week) will be taken for both the groups. Statistical analysis will be done.


Adolescents coming to the OPD or admitted in CCAP ward, Central Institute of Psychiatry, diagnosed with Dissociative Disorders according to ICD-10, will be interviewed. They will be briefed about the purpose of the study and their consent & assent will be taken
The socio-demographic details including name, address, age, sex, educational qualification, family income, family constellation and support system in the family would then be collected and a brief history of their illness would be taken along with administration of Screening tools SPM.
Based on clinical observation, findings after administration of screening tools, those who will meet the inclusion and exclusion criteria will be included in the study. Children and adolescents will be assigned to experimental or control groups using random number technique
Baseline assessment would be taken for both study group and treatment as usual group. Multidimensional Inventory of Dissociation , Affective Reactivity Index , Hamilton Anxiety Rating Scale), Childhood Depression Inventory.
Then McGill Illness Narrative Interview: An Interview Schedule to Elicit Meanings and Modes of Reasoning Related to Illness Experience will be administered where the lived experiences will be narrated by the patient and themes will be generated through that interview which can be dealt during the intervention for the study group following, Thematic Apperception Test Social cognition and Object relation Scale- Global Rating Method, Emotion Regulation Questionnaire for Children and Adolescents , Adolescent-Coping Orientation for Problem Experiences and ERP for
Group 1(25 Participants)
Intervention module (10 sessions to be given to the children and adolescents and 2 sessions to the family members on study group.
Group 2
25 Participants
Treatment as usual.
POST INTERVENTION ASSESSMENT 6 weeks (immediate end of intervention) and a follow up measurement after 1 month (10th week) will be taken.
STATISTICAL ANALYSIS

STATISTICAL ANALYSIS

The data will be statistically analysed. Appropriate statistical methods would be applied using the Statistical Package for Social Sciences (SPSS Version 25.0). Descriptive statistics will be used to describe sample population using chi-square test and independent samples t-test wherever applicable. Repeated measure ANOVA would be done to analyse group and time interaction. Pearson's correlation r will be used to see the association between the outcome variables and socio demographic variables. Level of significance (α) will be kept at 0.05 levels.

For qualitative data of narratives, themes and subthemes would be analysed using process of thematic analysis. The themes generated will be mutually rated by all authors and then concluded.

SIGNIFICANCE OF THE STUDY

Adolescents suffering from dissociative disorders display dysfunctional stress responses, anxiety, depression and emotional dysregulation due to certain Lived experiences as a result of which they might have low self-esteem along with maladaptive coping style. Eclectic Play Therapy targets all these above mentioned areas to improve clinical symptoms as well as build adequate skills. Play therapy helps in building adaptive skills to balance between rational mind and emotional mind.

RELEVANCE TO THE PRESENT-DAY PROBLEM AND NEED OF THE SOCIETY

Now-a-days, Dissociative disorder comes under frequently reported complaints among children and adolescents. Recent screening studies on dissociative disorders in various countries yielded life time prevalence rates of approximately 10% in psychiatric settings and in general settings (Sar, 2017). It is highly prevalent in children and adolescents. Relaxation therapy, contingence management, extinction, exposure based therapy and overall cognitive and behavioural therapy comes under evidence based practices in order to treat dissociative disorder. As Play Therapy is a relatively new emerging therapy, the number of well-designed prospectively registered randomized controlled trials (RCTs) may currently be limited. There is scarcity of any research on Play therapy on Dissociative disorders. However, some of the skills taken from Play therapy have been proven to be efficacious in this field. Henceforth, this study may be useful.

CONTRIBUTION TO THE EXISTING KNOWLEDGE

Several researches have been conducted on dissociative disorders. However, there are very few studies that use play therapy in dissociative disorders in children and adolescents. The present study will contribute to the existing literature by integrating the biological, dynamic and cognitive approaches and exploring its efficacy.

FUTURE WORK

Eclectic Play Therapy is an integrated therapy that draws from psychodynamic therapeutic approach based components. It is a new emerging therapy; and the number of well-designed prospectively registered randomized controlled trials (RCTs) may currently be limited. The therapy's role in relapse prevention and its role in efficacy in self-monitoring, enhancing positive coping skills and expressing ones suppressed feelings by manipulating the objects and having a sense of control to show how one is feeling. Play therapy has been used effectively in children and

adolescents ADHD, anxiety and depressive spectrum, and also in community sampling. A dearth of research application in this field warrants future work.

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